COUNTY OF LOS ANGELES - DEPARTMENT OF HEALTH SERVICES

NON-COUNTY PHYSICIANS

CALIFORNIA HEALTHCARE FOR INDIGENTS PROGRAM (CHIP)

FOR EMS USE ONLY
TRAUMA YES ☐
NO ☐

PATIENT INFORMATION*

COMPLETE ENTIRE CLAIM AND SUBMIT WITH HCFA-1500

1. TPS #: _____ 2. SOCIAL SECURITY NUMBER: ☐☐☐ ☐☐ ☐☐☐☐

3. PATIENT'S NAME _____
LAST FIRST MIDDLE INITIAL

(1) IF MINOR, PARENT/GUARDIAN: _____
LAST FIRST

4. PLACE OF BIRTH: _____
CITY STATE COUNTRY

5. MOTHER'S MAIDEN NAME: _____

6. ETHNICITY: (CHECK ONE)
☐ (1) WHITE
☐ (2) BLACK
☐ (3) ASIAN/PACIFIC ISLANDER
☐ (4) NATIVE AMERICAN/ESKIMO/ALEUT
☐ (5) HISPANIC
☐ (6) FILIPINO
☐ (7) OTHER

7. EMPLOYMENT TYPE:
☐ (0) UNEMPLOYED
☐ (1) FARMING/FORESTRY/FISHING
☐ (2) LABORERS/HELPERS/CRAFT/ INSPECTION/REPAIR/PRODUCTION/ TRANSPORTATION
☐ (3) SALES/SERVICE
☐ (4) EXECUTIVE ADMINISTRATIVE/MANAGERIAL/ PROFESSIONAL/TECHNICAL/RELATED SUPPORT
☐ (5) OTHER

8: MONTHLY INCOME: $ _____ 9. FAMILY SIZE (COUNT PATIENT AS 1): _____

10. SOURCE OF INCOME:
☐ (0) NONE
☐ (1) GENERAL RELIEF
☐ (2) WAGES
☐ (3) SELF-EMPLOYED
☐ (4) DISABILITY
☐ (5) RETIRED
☐ (6) OTHER, e.g., UNEMPLOYMENT/VA BENEFITS/INTEREST/DIVIDENDS/RENT/ CHILD SUPPORT/ALIMONY, ETC.

PATIENT INFORMATION VERIFICATION

*IF UNABLE TO OBTAIN INFORMATION FROM HOSPITAL, SUBMITTING PHYSICIAN/AGENCY MUST GIVE REASON(S) WHY INFORMATION WAS NOT OBTAINED AND MUST SIGN INDICATING EVERY ATTEMPT WAS MADE:

REASON(S): _____ (26)

SIGNATURE: _____ (27)

PHYSICIAN SERVICES

20. PHYSICIAN FUND:
☐ (1) CONTRACT TRAUMA
☐ (2) NON-CONTRACT EMERGENCY
☐ (3) PEDIATRICS
☐ (4) OBSTETRICS EDD: ☐☐☐

21. SERVICE SETTING:
☐ (1) INPATIENT
☐ (2) EMERGENCY DEPARTMENT
☐ (3) OUTPATIENT/OFFICE VISIT, CHECK ONE OF: ☐ a. PRIMARY CARE ☐ b. SPECIALTY CARE

22. PHYSICIAN'S NAME: _____ STATE LICENSE NO: _____

23. PAYEE NAME: _____ PAYEE TAX ID#: _____

PAYEE ADDRESS: _____

24. DATE BILLED COUNTY: ☐☐☐ CHARGES: $ _____

FOR QUESTIONS REGARDING CLAIM:

25. CONTACT PERSON _____ TELEPHONE NO: ( ) _____